

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10123

Reg. Dist. No. 193

1. PLACE OF DEATH:

County... Howard

City or town... Ridgeville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Edward Bennett

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. Bennett

7. Birth date of deceased (mo., day, yr.)

Oct. 10, 1870

6. (c) If alive, give age years

65

8. AGE:

Years

Months

Days

If less than one day

77

0

29

hrs.

min.

9. Birthplace

Frederick Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Ozzin Bennett

13. Birthplace

Md.

MOTHER

14. Maiden name

Eleanor Hobbs

15. Birthplace

Md.

16. Informant

Mrs. Mary E. Bennett

Address

Mt. Airy, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

11-12-1947
(month) (day) (year)

Cemetery or crematory

Pine Grove

Location

Mt. Airy, Md.

18. Funeral director

Address

Wm. J. Jones
E. Paul Jones

19.

(Date rec'd by registrar)

11/10-47

E. Paul Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Howard

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rural - Mt. Airy

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1947, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 15, 1943 to November 9, 1947

and that I last saw him alive on November 9, 1947

Immediate cause of death: Intracerebral cardio-vascular disease

DURATION

10 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James P. Kerr M.D.

M. D. or other

Address

Wm. J. Jones M.D.

Date signed 11/10/47

RECEIVED

NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10124

195

1. PLACE OF DEATH:

County HowardCity or town Jessups Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.Hospital, institution, or street address where death occurred: Shilford

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Jessups Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Shilford
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Boston

3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Flora Boston

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

? 1877

8. AGE:

Years

Months

Days

If less than one day

707?hrs.min.

9. Birthplace

Shilford

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

farmer

FATHER

12. Name

Nicholas Boston

13. Birthplace

md

MOTHER

14. Maiden name

Isabelle Kane

15. Birthplace

md.

16. Informant

Eliy Harris

Address

Jessups

17.

(Burial, cremation, or removal. Which?)

Date thereof

12-3-47
(month) (day) (year)

Cemetery or crematory

Ashbury

Location

Jessups R & A

18. Funeral director

HC Higginbotham

Address

Elliot City

19.

(Date rec'd by registrar)

12/4/47

19

Frank Shipley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 29 1947 at 8:45P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 29 1947 to November 29 1947and that I last saw him alive on November 29 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

7 hours

Due to

Hypertensive Cardiovascular Diseaseprobably 10-15 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Stephens, MD.

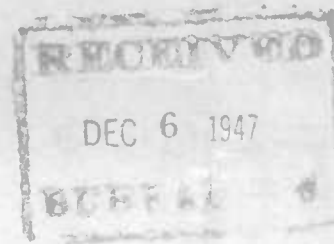
M. D. or other

Address

Laurel, Maryland

Date signed

11/29/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10125

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:

County Howard
 City or town Near Clarksville Highway 29
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Automobile accident
 Hospital, institution, or street address where death occurred:
Public Highway # 29
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Near Clarksville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Howard Dorsey

3. (b) Social Security Number

219-18-8644

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Minnie L. Dorsey
NEE Rice

7. Birth date of deceased (mo., day, yr.)

June 29, 1884

6. (c) If alive, give age

63 years

8. AGE:

Years

Months

Days

It less than one day

6343

hrs.

min.

9. Birthplace

Howard Co. Maryland
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Hammond Dorsey

13. Birthplace

Howard Co. Md.

MOTHER

14. Maiden name

Helen Pendleton

15. Birthplace

Richmond Virginia

16. Informant

Mrs. Minnie L. Dorsey

Address

Ellicott City Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Nov. 4, 1947
(month) (day) (year)

Cemetery or crematory

St. Johns, Pfliffers Corner

Location

Pfliffers Corner

18. Funeral director

E. A. Dorsey Sons

Address

Ellicott City, Md.

19.

11-3
(Date rec'd by registrar)47Marie A. Whitaker
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 19 47, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-1 19 47 to 11-1 19 47and that I last saw him alive on NO date 19 47

Immediate cause of death

Compound fracture of skull on left side

DURATION

instant

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-1-47Where did injury occur? Near Clarksville Howard Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public Highway # 29Means of injury Auto turned over Injured at work? no

23. SIGNATURE

George E. Burgtorf M.D.
acting Deputy Medical Examiner of Howard Co.Address Ellicott City, Md. Date signed 11-1-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 5 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10126

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard

City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Cittasville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Glenwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Peter Brandenburg

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Emma May Brandenburg

7. Birth date of deceased (mo., day, yr.)

May 22, 1874

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73

6

5

hrs.

min.

9. Birthplace

Fredricks Co. Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Amos Brandenburg
Md.

13. Birthplace

MOTHER

14. Maiden name

Alice Lakus
Md.

15. Birthplace

16. Informant

Paul Brandenburg

Address

Ellicott City Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

11-30-47
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Ellicott City Md.

18. Funeral director

F C Nig. whothorn

Address

Ellicott City Md

19.

Oct. 29,

19 47

(Date rec'd by registrar)

John B. Longhouse
Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 19 47 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-27 19 47 to 11-27 19 47 and that I last saw him alive on no date 19 47

Immediate cause of death

Coronary Thrombosis

DURATION

Instant

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Burdorf M.D.
acting Deputy Medical Examiner Howard Co.
Address Ellicott City, Md. Date signed 11-27-47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

G221 10/4/57: CHO P.C. L

Reg. Dist. No. 194

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				d. STREET ADDRESS 			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Stephen Boone Dorsey				4. DATE OF DEATH Month Day Year Nov. 14, 1947									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1857		9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Stephen B. Dorsey						14. MOTHER'S MAIDEN NAME Sarah Owings							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 				17. INFORMANT Address Mrs. Stephen B. Dorsey					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Aug. 22, 1946 to Nov. 14, 1947 that I last saw the deceased alive on Nov. 13, 1947 and that death occurred at 8 P. M. from the causes and on the date stated above. Charles S. Whitaker, M.D. Charles S. Whitaker (signed) Clarksville, Md. 11/15/47 ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D.													
PHYSICIAN'S NAME (Type) Charles S. Whitaker, Clarksville, Md.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-17-47		22c. NAME OF CEMETERY OR CREMATORY Oak Grove			22d. LOCATION (City, town, or county) (State) Glenwood Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbothom, Ellicott City, Md.						24a. REC'D BY REGISTRAR DATE Nov. 17, 1947		24b. REGISTRAR'S SIGNATURE Marie A. Whitaker					

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10/57-L

Note: Indexed, but Certificate missing; unfound.

Replaced herewith - H.O. Copy, filmed. If found, (original)
discuss this Certificate, - LL 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1572 10127

Reg. Dist. No. 190

1. PLACE OF DEATH:

County Howard
City or town Edgeridge Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Howard
City or town Edgeridge Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5410 W. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph F. Fuchs

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1947 8.(c) If alive, give age 47 years

8. AGE: Years 2 Months 2 Days 2 If less than one day
hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Crooner

11. Industry or business

12. Name Joseph F. Fuchs

13. Birthplace Baltimore, Md.

14. Maiden name Ruth Lett

15. Birthplace Baltimore, Md.

16. Informant Mr. Joseph F. Fuchs

Address 5410 W. Main St. Edgeridge, Md

17. Burial, cremation, or removal (which) burial Date thereof Nov. 4, 1947
(month) (day) (year)

Cemetery or crematory St. Augustine Roman

Location Edgeridge, Md

18. Funeral director John J. Koway & Son

Address 991 S. Spring Street

19. Nov. 4, 47 (Date rec'd by registrar)

(Signature of Registrar) Miss E. M. Williams

Address 1711 Selma Ave.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/47 1947 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Nov 3 1947
and that I last saw him alive on Nov 3 1947

Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to Coronary
Due to Cardio Vascular System

Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William H. Miller M.D. or other
Date signed 11/4/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
- NOV 6 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....*Howard*
 City or town.....*Jessups*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death.....*1 yr*
 Hospital, institution, or street address where death occurred:
Cedar Lane
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....*Maryland* County.....*Howard*
 City or town.....*Jessups*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*Cedar Lane*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Lillie Lifford

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*Colored* 6.(a) Single, married, widowed, or divorced.....*Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*August 31, 1928* 6.(c) If alive, give age..... years

8. AGE: Years.....*19* Months.....*2* Days.....*20* If less than one day..... hrs..... min.

9. Birthplace.....*Greenwood, South Carolina*
 (Town, county, and state)

10. Usual occupation.....*none*11. Industry or business.....*none*12. Name.....*Willie Lifford*13. Birthplace.....*Greenwood S.C.*14. Maiden name.....*Jessie Moore*15. Birthplace.....*Greenwood S.C.*16. Informant.....*Willie Lifford*Address.....*Jessups Md*

17. *Shipped* Date thereof.....*Nov. 22, 1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....*Greenwood, S.C.*18. Funeral director.....*Mrs. Katie R. Williams*Address.....*322 N. Schroeder St.*

19. *11/21* *1947* *AW Redick*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*November 20, 1947* at.....*3A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 20 19*47* to *Nov 20* 19*47*

and that I last saw him/her alive on *at no time* 19*47*

Immediate cause of death.....

Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Alpha N. Herbert M.D.

23. SIGNATURE.....

DEPUTY MEDICAL EXAMINER, CHARLES COUNTY M. D. or other

Address.....*Edwards City, Md* Date signed.....*11-20-47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10129

Reg. Dist. No. 150

1. PLACE OF DEATH:

County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

Lind ClinicHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3718 Kimble Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

RUTH ELIZABETH MAHANEY

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

James Wesley Mahaney8.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

August 30, 1899

8. AGE:

Years

Months

Days

If less than one day

4828

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Gilbert C. Bolgiano

13. Birthplace

Balto.

MOTHER

14. Maiden name

Elizabeth E. Luthardt

15. Birthplace

Balto.

16. Informant

Mr. James W. Mahaney

Address

3718 Kimbell Rd.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

11/11/47

(month) (day) (year)

Cemetery or crematory

Woodlawn Cem.

Location

Woodlawn, Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

11/10
(Date rec'd by registrar)19 47A. W. Hedrich
Registrar

J.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1947 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 26, 1947 to November 8, 1947and that I last saw him alive on Nov. 8, 1947

Immediate cause of death

Myocardial degeneration

DURATION

?

Due to

Hypostatic pneumonia2 days

Due to

Other conditions

Schizophrenia, Catatonic type6 wks.

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Irving J. Taylor

M. D. or other

Address

Ellicott City, Md.Date signed 11/8/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10130
194

1. PLACE OF DEATH:

County Howard
 City or town near Glenwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 80 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Glenwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

OLIVER SCOTT MILES

3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Isabelle Miles
 8.(c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) March 26, 1867
 8. AGE: Years 80 Months 8 Days 7 If less than one dayhrs.min.

9. Birthplace Howard County
 (Town, county, and state)
 10. Usual occupation laborer
 11. Industry or business

12. Name Oliver Miles
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown

16. Informant Isabelle Miles
 Address Glenwood, Maryland
 17. burial Date thereof 11-15-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Bush Park
 Location Near Cooksville, Md.

18. Funeral director H. M. Snyder
 Address Mt. Airy, Maryland
 19. 11-14-47 19 Marie A. Whitaker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 19 47 at 8:30P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
November 11, 19 47, to Nov. 12 19 47

and that I last saw him alive on November 12 19 47

Immediate cause of death Acute cardiac failure DURATION 24 hrs.

Due to Coronary artery disease 20 yrs.

Due to Arteriosclerosis 30 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker M.D. M. D. or other

Address Clarks ville, Md Date signed 11-14-47

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

VOLUNTARY RETURN

RECEIVED
NOV 17 1947
BUREAU

W. J. [illegible]
[illegible]

Reg. Dist. No. 191

..Date signed....11.....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 10 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10132
195

1. PLACE OF DEATH:

County Howard
 City or town Lanham R. F. D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Howard
 City or town Lanham R. F. D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Lanham
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Bertha Snowden

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Married

6. (b) Name of husband or wife William H. Snowden6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) April 24 1890

8. AGE: Years 57 Months 6 Days 29 hrs. min.

9. Birthplace Murphy P. O. Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Talmie13. Birthplace West Maryland Va14. Maiden name Mathilda Ann Williams15. Birthplace Murphy Md16. Informant William H. SnowdenAddress Lanham R. F. D.17. Burial Date thereof Nov 26 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Murphy MdLocation Murphy Md19. Funeral director Ridgely SelbyAddress 401 W. 1st St. Lanham Md19. 11/25/47 Frank Shipley
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1947 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17, 1947, to November 23, 1947, and that I last saw him/her alive on November 19, 1947.

Immediate cause of death Coronary Thrombosis DURATION 1 d

Due to Chronic Myocarditis 7 yrs

Due to Arteriosclerosis, generalized 10 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

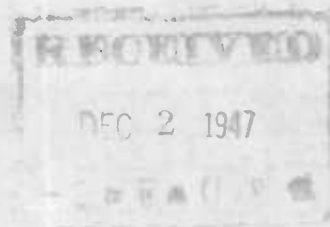
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stevens, MD M. D. or otherAddress Lanham Md. Date signed 11/24/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)Street No. 7ells Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Elizabeth (Elsie) Wilhemina Volckman

3. (b) Social Security Number

220-20-9080

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 12, 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59126

hrs.

min.

9. Birthplace

Baltimore Md
(Town, county and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Chas F W Volckman

13. Birthplace

Germany

14. Maiden name

Minnie Priestigater

15. Birthplace

Md

16. Informant

Chas Volckman

Address

Simpsonville Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

11-10-47
(month) (day) (year)

Cemetery or crematory

London Park

Location

Balds Md

18. Funeral director

F P Wignall & Son

Address

Ellicott City Md

19. Date rec'd by registrar

Nov 10, 1947

19. 47

John B. LoughmanP. B. E. S.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-819. 47 at 9²⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19. 47 to Nov. 8 19. 47
and that I last saw h. ee alive on 11-8 19. 47

Immediate cause of death

Carcinomatous

DURATION

8 mo.

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Buehler M.D.

M. D. of other

Address

Ellicott City, Md.Date signed 11-9-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

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NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

10133

Reg. Dist. No. 191-190

1. PLACE OF DEATH:
 County Howard
 City or town Harwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Howard
 City or town Harwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Halls Cabin
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Heeslee W. Wain

3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Wile B. Wain

7. Birth date of deceased (mo., day, yr.) 1903 8. (c) If alive, give age years

8. AGE: Years 44 Months Days If less than one day hrs. min.

9. Birthplace Alabama
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Chas. W. Wain

13. Birthplace Alabama

14. Maiden name unknown

15. Birthplace

16. Informant Wile B. Wain

Address Harwood, Md.

17. Burial Date thereof 11-18-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salem

Location Salem, Alabama

18. Funeral director F. C. Ideig, undertaker

Address Ellicott City, Md.

19. Nov. 17 1947 John B. Longhouse, Jr.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1947 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Nov 15 1947

and that I last saw him alive at no time 1947

Immediate cause of death

Fractures of all ribs and sternum

Due to Crushing injury

Due to

Other conditions Punctured lungs

Crushed mediastinum

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of 11-15-47

Accident, suicide, or homicide Accident Date of 11-15-47

Where did injury occur? Ellicott City, Md. (City or town) Howard (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Auto accident Injured at work? No

23. SIGNATURE Alpha M. Herbert, M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY, D. or other
 Address Ellicott City, Md. Date signed 11-15-47

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1903

NOV 20 1947
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11-18-47

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